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STATE OF DELAWARE

BOARD OF NURSING

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VERIFICATION OF EXPERIENCE AND COMPETENCY

INSTRUCTIONS

The purpose of this form is to verify the experience and competency of an Advanced Practice Registered Nurse (APRN) who is seeking independent practice in Delaware. The collaborator must review the entire form, sign it and mail it ***directly*** to the Board of Nursing at the address above. Forms not received *directly* from the collaborator will not be accepted.

1. APRN Name: _____ Delaware License (if any): L ___ - _____

2. Collaborator Name: _____

3. Business/Practice Name: _____

4. Location Address: _____
   (If more than one location, enter main location. *No PO Box!)*

5. Collaborator Phone: _____ Collaborator Email: _____

6. Provide the following information about **your** professional licensure:

   ☐ Physician ☐ Podiatrist ☐ Other: _____

   License Number: _____ Specialty: _____

7. Select the business/practice that best describes where the collaborative agreement with the APRN listed above took place (check all that apply):

   ☐ Healthcare organization ☐ Licensed healthcare delivery system ☐ Physician, podiatrist, or practice group

8. Your area of practice while you were the APRN's collaborator must be substantially related to the APRN's education, certification and planned independent practice. Check the APRN role for which you served as collaborator:

   ☐ Certified Registered Nurse Anesthetist (CRNA)

   ☐ Certified Nurse Midwife

   ☐ Certified Nurse Practitioner (NP) – Check ***one*** population focus area in this role:
   ☐ Adult/Gerontological ☐ Family ☐ Neonatal ☐ Pediatric
   ☐ Psychiatric/Mental Health ☐ Women's Health/Gender-Related

   ☐ Clinical Nurse Specialist (CNS) – Check ***one*** population focus area in this role:
   ☐ Adult/Gerontological ☐ Family ☐ Neonatal ☐ Pediatric
   ☐ Psychiatric/Mental Health ☐ Women's Health/Gender-Related

9. To practice independently in Delaware, an APRN is required to complete at least two years ***and*** at least 4,000 hours of clinical APRN practice. ***Enter the following information about the period when you were the APRN's collaborator***.

   Total hours of APRN clinical practice: _____

   Time period during which the APRN practiced: From _____ To _____
   Month/Year Month/Year

CERTIFICATION

I affirm under penalty of perjury that the foregoing statements are true and complete to the best of my knowledge.

Collaborator Signature:_____ Date: _____

MAIL THIS FORM DIRECTLY TO THE BOARD OFFICE AT THE ADDRESS ABOVE